MACROECONOMIC ADJUSTMENT POLICIES, HEALTH SECTOR REFORM, AND HEALTH CARE: AN INVESTIGATION OF THE MACRO-MICRO LINKAGES

SLIM HADDAD
Université de Montréal
Groupe de Recherche Interdisciplinaire en Santé
C.P. 6128, succ. Centre-Ville
Montreal, PQ Canada H3C 3J7
phone: (514) 343-7311
fax: (514) 343-7770
email: slim.haddad@umontreal.ca

JEANNIE HAGGERTY
Université de Montréal
Unité de Santé Internationale
Montreal, PQ Canada

KATIA MOHINDRA
International Development Research Centre
Strategies & Policies for Healthy Societies
P.O. Box 8500
Ottawa, ON Canada K1G 3H9
tel: (613) 236-6163 ext 2251
fax: (613) 567-7748
email: kmohindra@idrc.ca

MICHELLE CALLAWAY
Université de Montréal
Unité de Santé Internationale
Montreal, PQ Canada

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I. Introduction

This paper discusses the research initiative: “MacroEconomic and Adjustment Policies and Health Care: Studying the Macro-micro Links” (MAPHealth). The initiative was developed through a co-operative network of eight participating countries, the International Development Research Centre in Ottawa (IDRC), who initiated and funded the project, and the Groupe de Recherche Interdisciplinaire en Santé (GRIS) at the Université de Montréal, who developed the methodology, provided methodological assistance, and co-ordinated the project.

The purpose of this paper is to provide an overview of the MAPHealth project. First we describe briefly the conceptual framework and methodology of the project. Second, we describe aspects of context and coordination of the research project which themselves constitute a unique contribution. Finally, we address the strengths and the weaknesses of the project, and the future plans of the initiative.

II. Overview of the MAPHealth Research Initiative

Rationale

The impact of macroeconomic adjustment policies (MAPs) on social and health sectors has been the subject of considerable debate in the last two decades. In many countries, it has been alleged that the health sector has been seriously undermined as a direct result of MAPs, or indirectly through the deterioration of socio-economic conditions associated with the macro-adjustment policies' stabilisation measures.

Most work examining the effects of MAPs in the health sector has concentrated on *presumed* effects on population health. However, the results of these works were subject to intense debate and divergent interpretations. The controversy has been fuelled by the predominantly ideological nature of the debate and the paucity of solid, scientific evidence on possible health impacts of adjustment on populations.

Although there is a plethora of literature discussing the impacts of MAPs on health, research on the health system and health care remains scant and unsatisfactory. The present research initiative decidedly concentrates on the relationships between MAPs, health sector reform, and accessibility, utilisation and quality of health care.

As the title indicates, the initiative is interested not only in macroeconomic policies, but also in health sector reforms. In effect, most countries undergoing adjustment have also started or have completed one or numerous reforms of their health systems. These reforms generally propose profound transformations in the regulation, financing, and organisation of health systems. Thus, any appraisal of the effects of MAPs on health care outcomes presupposes an examination of the relationships not only between MAPs and health sector reform, but also between health sector reform and health care.

Objectives and Country Selection

The main research objectives of MAPHealth are to study the links between the adoption and implementation of MAPs and those of health sector reform, as well as to assess the links between MAPs, health sector reform (HSR), and accessibility, utilisation, and quality (AUQ) of health services. The project aims to re-examine the aforementioned linkages adopting a multi-disciplinary approach, systematic analysis and a rigorous scientific inquiry. The purpose of the study is to gather pertinent data information to sustain policy choices that affect the health system.

This unique initiative engaged multiple countries with each country study sharing a theoretical framework and common methodology. Country team selection was based on numerous criteria including multi-disciplinary research capacity, political stability, availability and reliability of country-level data, level of country development, and background and experiences with MAPs and health sector reform. The countries, including some key development indicators are listed in Table 1.

Table 1: Selected health and development indicators of MAPHealth Countries for 1998

Country	Human Development Index (HDI)	HDI Rank	Population (millions)	Life expec-tancy	Crude rate of school attendance
Mexico	0.784	55	95.8	72.3 yr	70%
Colombia	0.764	68	40.8	70.7 yr	71%
Thailand	0.745	76	60.3	68.9 yr	61%
India	0.563	128	982.2	62.9 yr	54%
Zimbabwe	0.555	130	11.4	43.5 yr	68%
Kenya	0.508	138	29.0	51.3 yr	50%
Uganda	0.409	158	3.6	40.7 yr	41%
Burkina Faso	0.303	172	11.3	44.7 yr	22%

Source: UNDP, 2000

Theoretical Framework

The influences of adjustment on health systems are at times complex and subject to multiple interrelationships. Considerable effort was invested in formulating a framework to conceptualise the direct and indirect influences of adjustment and sector reforms on the supply of, and demand for health care, and ultimately on the quality, utilisation and accessibility of health services. The resulting conceptual framework is presented in Figure 1 summarising the purported chain of causality from MAPs and HSR through intermediate variables to the ultimate variable, utilisation of health care services.

The framework has two distinguishing features, which informed the methodology and analysis:

- Two mechanisms of effects : (1) Supply side. Modifications in the regulation, organisation, and financing of health care systems are expected to affect the availability, price, and quality of health services. (2) Demand side. Modifications in economic climate of communities are expected to affect employment, resources availability, and consumption as well as health inputs such as nutrition, education, and risk exposure. These in turn are expected to modify health needs, ability to pay, perceptions of the price, of accessibility and of quality of health services. Ultimately, utilisation of health services effects will be influenced by the simultaneous changes in both supply and demand.

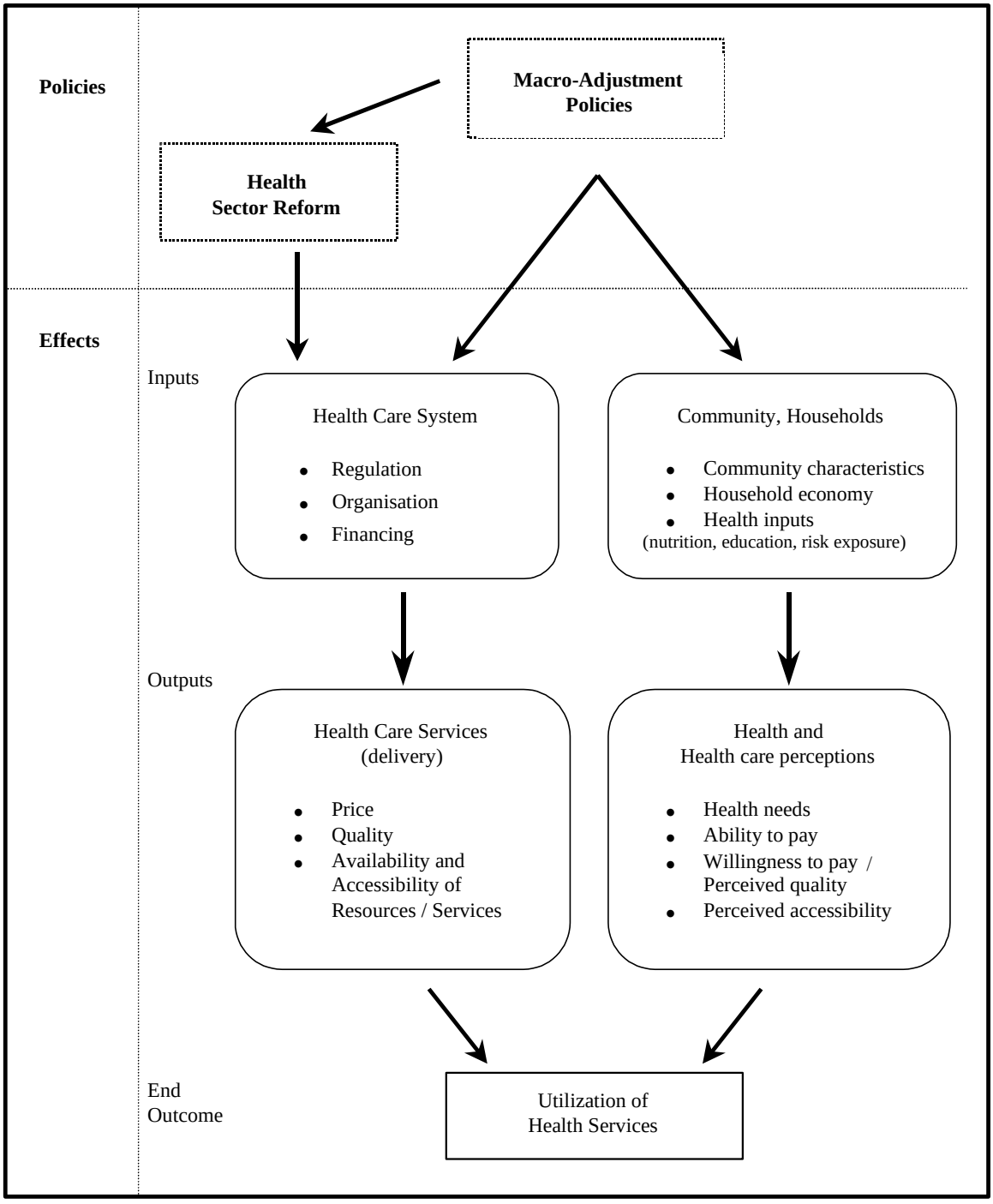
- Three levels of effects : (1) Macro-level: the effects of macroeconomic adjustment policies (including health sector reform) on the health care sector, and on the economic environment of communities (2) Meso-level: the effects of the macro-level changes on the supply of health services and on households influencing their demand on health care ; (3) Micro-level: the effects of all these modifications on the utilisation of health care by individuals who believe they need care.

Specific hypothesised effects arise from a more detailed examination of the mechanisms considered to be at work within this conceptual framework. From the supply side, adjustment directly influences the health care system through changes in the total amount, the distribution, and the allocation of public health resources. The prices of goods and services, especially imported goods (equipment, pharmaceuticals, consumer goods), also constitute a specific mechanism of effect. Health sector reforms, often considered an integral part of the majority of adjustment programs, are expected to substantially modify both the organisation of the health system, and the supply of services. As a result, the availability, quality, prices of services, as well as geographic, organisational and financial accessibility, may undergo profound changes.

On the demand side, austerity measures directly influence the economy and household consumption, affecting various health inputs as well as life conditions, which may possibly favour an environment that is deleterious to health, resulting in an increase in health needs. Also, combined changes in prices and household ability to pay will tend to increase health care opportunity costs particularly for lower socio-economic groups. Changes affecting the supply of services will modify people's perception of services and their willingness to pay. Ultimately, these changes will significantly modify accessibility and utilisation, heightening the risk of exclusion for the most vulnerable segments of society, such as the poor, women and children.

These are some of the *general* hypotheses that were proposed for the research, each country team also looked for *specific* ways in which their country would be affected within the proposed framework. The particular nature of the country-specific hypotheses resulted in some variation in the design and analysis of the project.

Figure 1. MAPs – HSR – Accessibility, Utilisation and Quality of care: The Theoretical Framework



Methodology

This project is a "multiple-case-multiple level study", each of the eight countries representing a case. It is also a multiple-level study because there are three levels of observation and analysis (macro, meso, and micro) conducted at national, regional and local levels. All countries share a similar methodology.

The design is both cross-sectional and retrospective (past 15 years) combining quantitative analysis of primary and secondary sources of data with qualitative analysis at different levels. The units of analysis include country, regions, households, and individuals. Each country conducted five studies, two national, and three regional studies (Appendix A). The national studies included the retrospective analysis of the health system and the implementation of MAPs. Two or three different regions in the country were selected to maximize the variation in the geographic/cultural context, regional differences in the implementation of MAPs, and structure and function of the health care system. Within these regions, the research team selected clearly defined administrative units of observation within which health centres were evaluated. Households were selected for study based on clearly established sampling probabilities.

Macro-level variables included both contextual variables (demographic, epidemiological, social structure, political, and economic), and variables related to MAPs (implementation, impact, duration, etc.). Meso-level variables concerned the health care system (organisation, regulation, financing, and delivery of health care and health services) as well as communities (social and economic organisation, political and community environment, local resources, needs and health behaviours, inequities, and gender-specific issues). Finally, micro-level variables were collected at both the facility level (information on accessibility, utilisation, and quality of care) and at the community level (household economies, resources designated for health, perception of the health care system, utilisation of services, and ability and willingness to pay for health services).

The general tools developed for MAPHealth reflect the three levels of measurement in the study: macro- and meso-level instruments with a guide, health facilities questionnaire with supplements and guide and household questionnaires (Appendix A). The largest methodological tool is the set of household questionnaires consisting of four modules, which gathers information of the household unit, individual household members (women and children in particular) and their AUQ of health care services.

Data analysis

Complex analysis and various modeling techniques are involved in MAPHealth; including strategies to integrate the various study levels (macro, meso, micro) and types of data (quantitative/qualitative, cross-sectional/retrospective) to address the general and country-specific hypotheses. Country teams were strongly encouraged, with methodological support, to use multilevel analysis techniques. Multilevel modeling is becoming the gold standard approach in health research and other social sciences when analysing hierarchical data sets for which traditional analytical techniques are inappropriate. Multilevel models allows the examination of micro-level influences in parallel to those of macro-level on the outcomes variables taking into account their respective contributions. They help to appropriately model contextual and compositional

effects at the macro level, as well as protecting the researcher from aggregation bias and problems related to non-independence. These difficulties occur if data are examined at the micro-level without regard to the nested structure.

There are five steps to the analysis:

1. Analysis of the main features of the Structural Adjustment Program in the country;
2. Analysis of the main structural features of the health care system;
3. Assessment of the main community features;
4. Assessment of the outcomes of accessibility, utilisation, and quality of services in the health care system; and,
5. Integral analysis of the relationships between MAPs, community conditions health care system structure, and the response variables.

For each country team, the challenge to data analysis is in the integration of the multiple types and levels of data to address the hypotheses. Extensive support was given to help each team face this challenge. The specific ways in which the data are integrated varies from country to country depending on their methodological backgrounds. There is no suggested “recipe” for data analyse *per se*, but rather a general iterative process, using both a ‘top-down’ and ‘bottoms-up’ approach (Table 2). At each step, the analyst integrates new information, re-evaluating and re-formulating hypotheses, looking for patterns in the data. The analyst begins by examining macro-level factors based on a set of general hypotheses. This analysis stems from an examination of the contextual nature of reforms, determining what happened before, during, and after reforms. New hypotheses are then formulated at the regional level, based on macro-level interpretation. Regional impacts are assessed by extracting and integrating information from the household surveys, and health facilities surveys, complemented by qualitative information. This information can be subsequently used to modify the original hypotheses. Once there is congruency among the national and regional levels, the analyst moves down to the local level generating a new set of hypotheses. Drawing on local surveys and qualitative information, the process of analysis is repeated. The iterative process, now involving all three levels, continues until the integration is exhaustive.

Table 2. Suggested Process for Data Analysis

	Study Level		
	National	Regional	Local
Purpose	1. Define / Measure interventions (SAP, HSR) 2. Assess National impacts 2.1 Health system (regulation, organisation, financing, delivery) 2.2 Demand factors (needs, ATP, perceived quality, accessibility)	1. Implementation of reforms 2. Assess Regional impacts quality prices accessibility coverage needs utilisation	1. Implementation of the reform 2. Assess Local impacts quality prices accessibility coverage needs utilisation
	Modifiers (Implementation/Politics)		Modifiers (Implementation/Politics)
Process	Hypotheses (study proposal) Data analysis (MAPs & HSR)	DATA ANALYSIS Hypotheses Data analysis INTEGRATION	Hypotheses Data analysis (Surveys)
Design	Historical review & Pre-post	Cross sectional (HH & HF) & Qualitative	Local surveys & Qualitative
Methods	Trend analysis Before/After analysis Compare with previous studies Multivariate single level analysis Multivariate multiple level analysis Simulations	Trend analysis Before/After analysis Compare with previous studies Multivariate single level analysis Multivariate multiple level analysis Simulations	- Single case analysis (within) - Trend analysis (qualitative) - Before/After analysis (qualitative) - Multiple case analysis (between) - patterns - replications

Special populations

Data analysis pays special attention to the effects of MAPs and HSR on specific sub-groups where significant contrasts may exist, such as among social groups or geographical location. These distinctions are important because certain groups (e.g. the poor, women, workers in the informal sector) are more vulnerable than others to policy reforms. For example, the introduction of cost recovery systems into health care services will have a greater impact on the poor who do not have the same capacity to pay as people who are economically better off.

From the outset, we were concerned about greater potential for a negative effect on women and children. Consequently, gender considerations have been incorporated throughout the planning, design and analysis of the project. The instruments were carefully designed to promote sex-specific analyses. Gender variables have been included in all levels of analysis (macro, meso, micro). This study provides a particular focus on understanding the impact that MAPs and HSR have had on the intra-household allocation of resources, women's work burden (monitoring women's time), and barriers women face in accessing health services.

III. MAPHealth Features and Working Principles

The mandate of IDRC in promoting research in developing countries, explicitly includes strengthening research capacity. As a result, an important process objective of this project was to maximize the participatory nature of methodological decision-making, to foster opportunities for South-South and North-South scientific collaboration and transfer of knowledge.

A. Participatory

A strong participatory component is a key and unique feature of MAPHealth. In addition to the typical administrative role, IDRC was substantially involved in the methodological development of the research component. Moreover, the MAPHealth *network* followed an extremely consultative process. All major decisions were taken together at annual workshops, attended by country team leaders, Université de Montréal, and IDRC. The general outline of the project, coordination of teams, scheduling of activities and methodologies were all discussed and approved at these workshops. The last workshop established country report committees, to design a 'template' of the report, and to review research reports submitted by teams.

B. Transfer of knowledge

The project is based on intricate and complex methodology, with strong technical support by IDRC and Université de Montréal. At the core of the methodology was the development of the study design and the survey tools (macro-meso level instruments, and the health facility and household questionnaires). These items were available in English, French and Spanish, and were supported by accompanying guides. Throughout the course of the project new methodological approaches, data analysis techniques, and

available scientific resources (e.g. sources of data, reference materials) were introduced. The complex methodology of the project stimulated the development of numerous guides and tools to assist teams in collecting and analysing data (Appendix B). Countries are also receiving support in the preparation of their country reports, and in the dissemination of results. This important and often overlooked process, includes the provision of feedback on content, presentation of results, and the organisation and editing of the reports and other relevant documents.

Methodological assistance and technical advice were provided through the annual workshops, and on-site team visits by the Université de Montréal. Reference materials and technical advice were shared via ongoing electronic communications, and a project website.

C) Scientific Collaboration and Country Initiatives

Several teams used the same system to enter their data. The Indian team developed a data entry system based on the questionnaires canvassed in India, which they subsequently shared with the *network*. This system was extremely useful to the project as it increased data comparability among the countries that adopted the system. This initiative also illustrates an example of a South-South collaboration.

The four African teams have organized themselves into a regional network. One of their activities will be to present at an upcoming *Equinet* conference in South Africa, providing an African perspective of MAPHealth. In addition, two teams have initiated co-operative projects with the Université de Montréal and have submitted protocols to be funded by the Alliance for Health.

Comparative analyses are part of the next phase of the project. Three different routes of comparisons are being pursued. First, an inter-country comparison of the macro variables will document the evolution of health systems and various socio-economic trends. This type of comparison may illustrate the diversity of country experiences and the changes that have taken place over the past fifteen years. Second, a qualitative meta-analysis will be used to analyse the results in the country reports. Steps are currently being taken to ensure the highest possible level of standardisation of these reports. This type of comparison will strengthen conclusions of the linkages between MAPs, HSR and accessibility, utilisation, and quality of health services. Third, various sub-themes of the project (such as ability to pay) will be explored. The specific topics, as well as the participating countries will be decided on the basis of team interests and on the quality of the data. This will be a country-initiated process, involving partnerships among teams, thus, increasing South-South collaborations in the project.

Teams benefited by various group workshops and trainings, and received extensive methodological assistance by the Université de Montréal. Teams have gained skills in surveying techniques, data management and statistical analysis, which they can continue to use in the long term, and subsequently share with colleagues and students. Finally, teams received various research-related commodities, such as software (*MLWin, PolicyMaker*) and reference materials. Overall, MAPHealth has contributed to increased team capacity in multi-disciplinary and multi-level research and analysis.

IV. Where are we?

Countries have completed their field studies and are currently finishing the first draft of their country reports. These reports will be posted on the MAPHealth web site and reviewed by a special committee and other *network* members. Final reports should be ready by January 2001. There will be a final workshop held early in the year 2001. This will be a wrap-up workshop to discuss the final country reports, cross-country analyses and plans to disseminate project results. The main source of dissemination will be a monograph containing the general methodology and theory of the project, the individual country reports, and cross-country analyses. It is hoped that this monograph will be completed by December 2001. A synopsis of each country's progress including details of their experience with MAPs and health sector reform is reported in the Annex of the paper.

V. Strengths and weaknesses

A project of this magnitude undoubtedly has both strengths and weaknesses. The main weaknesses can be attributed to the complex and ambitious nature of the project. The project was demanding on team resources-both time wise and financially. The underestimation of this complexity led to some unexpected delays, and increasing budgetary constraints over the duration of the project. Developing and maintaining a comparative methodology was a difficult and time-consuming process, given the number of participating countries, the depth of the research and the intricacy of the methodology, and differences in the baseline research capacity. Teams, however, continue to pursue the project goals in spite of these difficulties.

An outstanding strength of this project is the vast amount of comparable data obtained, as well as the systematic gathering of secondary data. This information may now be stored in a "data warehouse", by assembling and organising the data in an easily accessible fashion. Teams would then be able to tap this resource by using the data to examine new themes and research questions.

A key strength of the project was research capacity strengthening. Country teams enlarged their capabilities, to produce unique and important contributions to health systems research. Moreover, teams will be able to capitalize on methodological aspects for future projects. A third important strength of the project involved the MAPHealth *network.* This *network* brought together researchers around the globe who share similar interests and a desire to work together for common research goals. MAPHealth encouraged partnerships among *network* members, research teams, and institutions. These project strengths have not only addressed important research issues in the South, but also provides a gateway to future potentialities in the participating countries.

VI. Where do we go from here?

There are three main priorities of MAPHealth for the future. The first priority will be to "close the loop". Appropriate strategies will be developed to extract and disseminate project results to key people, such as the Ministry of Health. In this way, teams will be able to influence, and to help define public policies.

The second priority will be to exploit the vast amount of data collected by conducting further analyses and to possibly use what has already been collected as baseline data for future research. There is great potential because of the quality, amount, and importance of the collected data. Teams may follow-up on key sub-themes and issues that are particularly relevant and of interest to their country.

The third priority will be to capitalize on MAPHealth by addressing essential research questions in the field:

1. reducing exclusion in health, and inequities in access to health care,
2. defining appropriate public policies to make health systems more efficient and equitable, and
3. understanding the challenges faced by health systems in the face of globalisation.

Preliminary discussions are underway among the partners for a possible follow-up, "MAPHealth-II" project. Such a project would maintain the essential principles of MAPHealth-I: a participatory, research capacity building, multiple-case-multiple level study. Similar to the first project, teams would share research questions and a common methodology. There could, however, be some flexibility introduced within these frameworks and methods. For example, teams may use different "tracers" to address the same issue on globalization (one team selects tobacco, another selects managed care, a third selects health tourism).

The project would continue working on the health sector within the context of global changes, while focusing on health inequities. There are two important perspectives of equity in relation to health care. The first perspective envisions equity in terms of horizontal-equal treatment for equal needs- and vertical equity-unequal treatment for unequal needs- (addressing resource allocation, access to care, and utilisation of services). The second perspective is concerned with both procedural justice (resource allocation, community participation and access to care), and distributive justice (health service utilisation and health outcomes). Incorporating these critical issues into an effective methodological framework may provide an important step towards protecting the most vulnerable groups from policy action taken at global and macro levels.

V. Conclusion

The MAPHealth project has addressed measurement difficulties by attempting to disentangle the linkages between MAPs, health sector reform, and the health care system through the implementation of a similar research methodology in 8 countries representing major regions of the world. The project contributes important new data, including a careful documentation of the evolution of each country's health care system. These accomplishments enables health system research to be brought out from under the "ideological cloud", by gaining a clearer picture based on solid research findings.

The paper illustrates the importance of examining health care outcomes, the accessibility, utilisation and quality of health services, in order to explore the impacts of, and relationships between MAPs and health sector reform. A deeper understanding of

accessibility, utilisation, and quality of health services is crucial in order to address reductions in health inequities, by increasing the accessibility of measures in achieving good health. Recently, there has been a resurgence of interest in equity in general and equity in health in particular. This may be attributed to both the growing disparities among the rich and poor (and other advantaged and disadvantaged groups), and also to the increasing role and importance allotted to health in development. An important step to narrowing health and poverty gaps will be to ensure that disadvantaged groups receive greater accessibility and utilisation of quality health services.

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Appendix A– Study design

Level	Study - Survey	Data collection: Sources		Instruments
		Primary sources	Secondary sources	
National	Health System Study (HSS)	Interviews Focus Groups	Policy plans, Reports, Previous Surveys, System Data, Statistics, etc.	Health System Kit
	MAP Study	Interviews Focus Groups	Policy plans, Reports, Previous Surveys, System Data, Statistics, etc.	MAP Kit
Regional	Community survey (CS)	Interviews	Reports, Previous Surveys, System Data, Statistics, etc.	Community check List
	Health Facilities Survey (HFS)	Interviews Observations	System Data, Statistics, Reports	HF Questionnaires (3)
	Household Survey (HHS)	Interviews	Databases	HH Questionnaires (4)

Appendix B: Guides and Tools Distributed to MAPHealth Teams

Guide or Tool	Description
Surveying Tools	• Macro- and meso-level instruments • Household Survey + guide • Health Facilities Survey + guide • Community Survey + guide
Methodological guide for the collection and analysis of Macro- and Meso-level variables	• Recommendations and information sources for the collection of contextual variables. • Structural Adjustment Analysis Kit • Health System Analysis Kit • Community Checklist
A guide to the preparation of data for analysis of the household questionnaires	• Recommendations and guidelines for data entry (data structure, variable names, coding, data checking). • Recommendations and guidelines for data management and internal validation. • References and technical advice on preparing key variables (e.g. ATP).
Proposed set of core relationships to be tested under the MAPHealth project	• 74 generic hypotheses relating to 6 set of relationships: 1. Expected outcomes of SAPs on HSR 2. Expected effect of SAPs and HSR on the health care system. 3. Expected effect of changes in the healthcare system on healthcare services (delivery). 4. Expected effect of SAPs on communities and households. 5. Expected effect of changes in communities and households on health and healthcare perceptions. 6. Expected effect of changes in health care services **and** changes in health and health care perceptions **on** utilisation of services.
Proposed template for country reports	• Principle content and sequence for the country reports
Key Concepts: A Selection of Papers	• Collection of papers of key concepts in MAPHealth: Health measurement, Socio-economic status, Ability to Pay, Willingness to Pay, Coping Strategies, Perceived Quality, Utilisation, Community Participation, Gender Issues, and Multilevel Analysis.

Note: All guides and documents were developed by the Université de Montréal except for the guide to the preparation of data which was prepared by the Université in conjunction with the Centre for Development Studies (CDS) and the proposed template for country reports which was prepared by a committee of several MAPHealth *network* members.

Annex-MAPHealth Country Progress

A synopsis of each country's progress is reported below and is followed by two tables. The first table provides more detailed information concerning the structural adjustment and health sector reform measures instituted in each of the eight countries. The second table contains the sampling methodology used for the three field studies: the community study, the health facilities study and the household study.

COLOMBIA

IMF-supervised MAPs were implemented in Colombia from 1984 to 1986. There were four periods of health sector reform between 1982 and 1998, corresponding to the presidential periods. In 1991 the country adopted a new constitution which laid the groundwork for an extensive health sector reform in 1993. These reforms aimed to increase health insurance coverage to the Colombian population and ensure universal access to a basic package of services by the year 2010 (Law 100).

Unlike other research teams, the Colombian team is relying on previously completed household studies. For the remaining field studies, two regions were selected on the basis of their differing socio-economic profiles. The analysis of the effects of MAPs and HSR on AUQ is nearing completion and a final report is forthcoming. The preliminary results were presented at an international conference in May, 2000.

Preliminary Results

Since the implementation of the health reforms, equitable access to health insurance and services has improved. For example, health insurance coverage increased from 23% to 57%; with a concomitant exponential increase in the health budget. Utilisation in terms of medical visits and hospitalisation also increased by 46% and 69%, respectively, between 1993 and 1997.

MEXICO

Since the early 1980's Mexico has undergone several economic crises followed by classical macroeconomic adjustment packages. Each package was accompanied by reductions in the public budget for health. Health sector reform in Mexico occurred in two phases. The first phase (1982-1988) was characterised by the structural reform of the health sector, during which time health services were integrated to form a national health system. Major alterations occurred in the health and private sectors during the second phase (1995-2000) of the reform, including the provision of a basic package of services for marginalised groups, family health insurance and decentralisation.

The Study was carried out in three different states, representing varying levels of economic development. The Mexican team also undertook two additional political and qualitative studies. The former study aimed to delineate the political processes that may modify the implementation of the administrative and health sector reforms. The latter study consisted of interviews with health service users and providers concerning health

sector reform. The data analysis will be completed at the end of August and a final report is expected for the end of September, 2000.

Preliminary results

The preliminary results suggest an association between MAPs implementation and health sector reform. During the 15 year period of study, there was a real decrease in the budgets of both the ministry of health services and the social security system.

THAILAND

The first IMF loan was sought in 1985 in response to the second oil crisis of 1979-85. In 1997, the Asian economic crisis precipitated a currency exchange crisis in Thailand, and the Government approached the IMF for a second loan. There are three distinct periods of health sector reform in Thailand. A primary health care policy and free medical scheme for the poor was instituted during the first period (1975-1980). The expansion of the health welfare program and the promotion of the public-private health care mix occurred during the second period of 1990-95. Since the third period, which commenced in 1999, reforms have been made with the civil servant medical benefits and payment scheme for the poor.

The study was carried out at the regional level, in a wealthy and poor province from each of the four regions in the country. The Thai team is currently in the process of doing more in-depth analyses at the macro level as well as integrating the macro data with the community and household studies. The preliminary results were presented at an international conference in May, 2000, and a final report is expected shortly.

Preliminary Results

The results to date demonstrate that access to health coverage has improved. For example, the total percentage of people with health insurance coverage increased from 33% in 1991 to 78% in 1998. There has also been a substantial increase in the Ministry of Public Health (MOPH) budget during the last 10 years, and the proportion of MOPH hospitals increased from 35% in 1973 to 65% in 1999.

INDIA

India underwent structural adjustment in 1991 under the supervision of the IMF. MAPs were implemented in the monetary, external and fiscal sectors and were aimed at stimulating market-led growth. Health is a state issue in India, and consequently health sector reforms differs amongst the states. For example, Orissa is amongst a number of states, borrowing from the World Bank to restructure their health sector. Kerala, however, decentralised the health sector, as part of a broader decentralisation effort.

Three states were selected for the study on the basis of their large inter-district variations. All of the data have been analysed, and the remainder of the final report is expected shortly.

Preliminary results

Three major combinations of health care environment and health sector reform situations may be observed among the states selected for detailed study. A mix of large public and private health care facilities in both urban and rural areas with decentralisation of the public sector was observed in Kerala. Orissa is characterised by public sector-dominated health care, with user fees first being introduced in 1997. Chennai, the capital of Tamil Nadu, experienced neither health sector reform nor decentralisation and is characterised by a mix of large public and private facilities.

Quality of service (in the infrastructure and process sense) has suffered in the public health care sector in all the states. However, the availability of drugs and medicines has not been affected in this respect. In Orissa , the quality of public facilities as perceived by the people is poor and that of private facilities is better. Utilisation rates of services in the public sector are declining. The squeeze on government spending on health has affected the construction and maintenance of buildings and equipment in the public sector in all the states.

Physical and economic access to public care is good in Chennai, as the city has a large number of health posts and maternity homes in addition to the secondary and tertiary care facilities. In Kerala, in both the rural and urban areas, physical and economic access to public care is good. In the urban areas, access to primary care is poor as these are provided by the large secondary care facilities. In Orissa, access is relatively poor. HSR is a state level issue.

(See MIMAP paper by India for more detailed information).

KENYA

IMF-assisted structural adjustment programs were first introduced in Kenya in 1980 after severe structural distortions in the economy led to a widespread economic crisis. Deteriorating economic conditions led the government to seek a second loan in 1982. During the period 1985-1991, the adjustment policy had shifted from broad-based to sectoral packages and in 1989, and SAPs were implemented in the health sector. Many of the reforms conditioned by these sectoral loans have been brought to completion during the current enhanced structural adjustment era (1992-present).

The Kenyan study was conducted at the national level in each of its eight provinces.
Data analysis examining the effects of MAPs and HSR on AUQ is currently underway and a final report is expected shortly.

ZIMBABWE

The first major alteration to the Zimbabwean health care system took place during the decade following independence in 1980 with the adoption of the “Equity in Health” policy aimed at addressing the deep inequalities in the national health care system. Declining economic growth during this decade led the government to respond by implementing a five-year Economic Structural Adjustment Program (ESAP) in 1991, funded by the IMF and the World Bank. A second set of structural adjustment reforms were initiated in 1996, within the context of the Zimbabwe Program for Economic and Social

Transformation (ZIMPREST), and were designed to strengthen prior reforms and eliminate structural weaknesses within the economy.

The study on macroeconomic and health sector reform in Zimbabwe was conducted at the national-level in each of the 10 provinces. The data have been analysed and a final report is expected in the near future.

UGANDA

Uganda experienced long periods of political instability and economic crises during the 1970's and 1980's. Two phases of MAPs were introduced during this time; the first phase occurring 1980-84, and the second phase began with the introduction of a World Bank/IMF structural adjustment program in 1987. HSR was officially launched in 1992, emphasising decentralisation.

Four out of five regions were selected (the North region was excluded due to political instability) for the study. One district was selected in each region, where 300 households were sampled, for a total household sample size of 1200. Four health centres were selected within each district.

The field studies and analyses have been completed and a final report is expected soon.

BURKINA FASO

Between 1966 and 1999, Burkina Faso had three distinct periods of structural adjustment. Prior to 1991, the country had its own national SAPs ("auto-adjustment"). However, marked economic difficulties led them to seek financial assistance in adopting classic IMF-World Bank packages in 1991. Health sector reforms were initiated in 1991 as an integral component of MAPs and included decentralisation, privatisation, cost-recovery, and reforms in the hospital, pharmaceutical, and traditional medicine sectors.

The study on macroeconomic and health sector reform in Burkina Faso was conducted in three regions. The data have been analysed and the first draft of the final report has been received. A final draft is forthcoming.

Results

Access to primary-level health care facilities has improved, with the distance for travel reducing from 15 km in 1980 to less than 10 km in 1999. The results of the household studies revealed that this improved access has been recognised by the local population. However, this has not been not accompanied by an increase in utilisation, which has continued to decline since 1989, with a per capita rate of utilisation dropping from 32% in 1984 to less than 18% in 1997. This reduction in utilisation is likely due to the poor quality of services and barriers to financial accessibility.

Table 1. The Implementation of Macroeconomic Adjustment Policies and Health Sector Reforms in the MAPHealth Countries of Study

COUNTRY	IMPLEMENTATION of IMF/World Bank-ASSISTED MAPs	HEALTH SECTOR REFORM
Colombia	**1984-86**. Severe adjustment programs implemented in the fiscal, exchange, trade areas and the foreign debt. Tax increases, administrative budget cuts, wages of public employees adjusted to below inflation, import surcharges, devaluation and domestic inflation.	**1993**: Law 100- Purpose was to increase health insurance coverage and to ensure universal access to basic packages of services. Four stages in health sector reform corresponding to the presidential periods: **1982-86**: Reform foundations-improve health system. Incentives for private enterprises in health technology. **1986-90**: Partial reform-administrative decentralisation, integration of public, private and social security organisations. Participation of private sector discussed for the first time. **1990-94**: Radical reform-creation of new health system supported by social security schemes for health and demand subsidies. Adoption of primary care model. **1994-98**: Reform implementation- established contributive and subsidised regimes.

COUNTRY	IMPLEMENTATION of IMF/World Bank-ASSISTED MAPs	HEALTH SECTOR REFORM
Mexico	Several classical packages implemented since **1982**. Each package was accompanied by reductions in the public budget for health. The usual duration of these packages was five years.	**1982-1988** Phase I - structural reform. Health services integrated to form a national health system. The universal right to health protection was incorporated into the Constitution in 1983 (General Health Law). **1995-2000**: Phase II -Intense transformation of the health, social security and private sectors. Provision of basic packages of services for marginalised groups, introduction of competition amongst service providers, provision of family health insurance, decentralisation and encouragement of local participation via healthy *municipios* program.
Thailand	**1985**: IMF loan in response to second oil crisis of 1979-85. Foreign exchange and external debt policies implemented. The exchange rate was fixed to a number of currencies, foreign borrowing in the public sector was limited and the currency was devalued in 1981 and again in 1984. **1997**: Second IMF loan sought after Asian crisis which commenced in July 1997. Symmetric flexibility to interest rate, raise tax revenue, government budget cutting and maintaining a current account surplus.	**1975-1980**: PHC policy, free medical scheme for poor. **1990-1995**: Expansion of health welfare program, promotion of public-private health care mix, health card scheme. **1999-present**: Reforms of the civil servant medical benefits and payment scheme for the poor
India	MAPs implemented in the monetary, external and fiscal sectors in **1991** under the supervision of the IMF. Structural reforms occurred in the areas of industrial, trade, and financial liberalisation and were aimed at stimulating market-led growth .	HSR is a state level issue. Orissa is amongst a number of states, who borrowed from the WB to restructure their health sector. Kerala has decentralised the health sector, as part of a broader decentralisation effort.

COUNTRY	IMPLEMENTATION of IMF/World Bank-ASSISTED MAPs	HEALTH SECTOR REFORM
Kenya	**1980-84**: Implementation of broad-based programs. Currency devaluation, reduction of government spending, decontrol of prices, liberalisation of economy, creation of export incentives, budget rationalisation. **1985-91**:Shift from broad-based to sectoral packages in agriculture, industry and the financial sector. **1992-present**: Enhanced structural adjustment era- many reforms brought to completion.	**1989**: Adjustment programs implemented in the health-sector and based upon alternative sources of health sector financing, cost-recovery, risk coverage schemes, strengthening of the private sector , decentralisation and a national drug policy.
Zimbabwe	**1991-1995**: Phase I (ESAP†) aimed at increasing investment and restoring economic growth. Trade and labour market liberalisation, deregulation, devaluation of local currency, removal of subsidies, restructuring of parastatals, reduction of the government budget deficit, privatisation and rationalisation of public sector employment. **1996-2000**: Phase II (ZIMPREST‡) designed to strengthen prior reforms and eliminate structural economic weaknesses. Selective price controls, increase in tariffs, import licensing on some goods, increase tariffs on regional imports, tariffs bound at higher levels than applied rates, applied tariffs increased, pegging of the exchange rate, suspension of foreign currency accounts, tobacco levy and introduction of export incentives in budget.	**1980-89**: "Equity in health policy" adopted to address the inequalities in health care. Advocated the Primary Health Care approach in the provision of services. **1990-2000**: Broad-based health sector reforms implemented in health financing, decentralisation and the private sector. Decentralisation, cost recovery, health financing, regulation of the private medical sector, management strengthening and contracting out. Introduction of the Social Development Fund to cushion the potentially deleterious effects on the poor. There is debate as to whether HSR was part of MAPs, or a response to them.

COUNTRY	IMPLEMENTATION of IMF/World Bank-ASSISTED MAPs	HEALTH SECTOR REFORM
Uganda	**1980-1984**: Phase I of MAPs. **1987**: Phase II of reforms begin under IMF/IBRD- liberalisation, stabilisation and institutional reforms (including privatisation and decentralisation), removal of trade barriers, broadening the tax system, movement towards market-determined exchange rate.	Decentralisation (**1992**) with a devolution of decision-making powers for health services to the district level. Enhance role of the private sector and develop an integrated public-private system at the district level and health financing reforms, such as cost sharing, insurance and community financing schemes. HSR not linked to MAPs.
Burkina Faso	**1966-1999**- 3 periods of adjustment. Prior to 1991, Burkina Faso had their own national SAPs ("Auto-adjustment"). **1991**: First IMF-WB structural adjustment package implemented with the intent of integrating the country into the market economy. Included simplification of taxation system, compression of public expenditures, liberalisation , rationalisation, reform on price fixing, restructuring of banking sector and currency devaluation. These reforms accompanied five sectoral reforms in the areas of agriculture, public enterprise, environment, transport and human resources.	**1991**: HSR initiated as an integral part of SAPs: decentralisation, cost-recovery, rationalisation, hospital reform, privatisation, collaboration with traditional medical sector and liberalisation. Decentralisation- with an emphasis placed on health districts within the country. Cost-recovery- introduction of user fees in health centres. Rationalisation- of the supply and distribution of generic medications at an affordable price. Reform of hospital sector to improve effectiveness. Promotion of private medicine. Collaboration between traditional and modern medicine. Liberalisation of health services has increased substantially during the past decade.

† ESAP: Economic Structural Adjustment Program; ‡ ZIMPREST: Zimbabwe Program for Economic and Social Transformation

Table 2. Sampling for the Community, Health Facilities and Household Field Studies
In each of the Eight MAPHealth Countries

Study	Colombia	Mexico	Thailand	India	Kenya	Zimbabwe	Uganda	Burkina Faso
1. COMMUNITY STUDY								
No. Regions	2 regions	3 states	8 provinces	3 states	NA ‡	2 provinces	NA ‡	3 regions
No. Communities/ Districts	3	5	39	6	NA ‡	2	NA ‡	53
No. Interviews	3 Focus Groups	148	189	297	NA ‡	30	NA ‡	NA ‡
2. HEALTH FACILTIES								
No. Regions	2 regions	2 states	8 provinces	3 states	8 provinces	8 provinces	4 regions	3 regions
No. communities/ Districts	25	40	39	6	13	NA ‡	NA ‡	53
No. facilities	40	48	255	75	24	24	48	14
No. Personnel	NA ‡	224	954	106	142	NA ‡	368	121
3. HOUSEHOLD STUDY								
Level	National †	Regional	Regional	Regional	National	National	Regional	Regional
Sampling	2 ° data	Random	Random	Random	Random	Random	Non-random	Random
No. Regions	2 regions	2 states	8 provinces	3 states	8 provinces	10 provinces	4 regions	3 regions
No. Communities/ Districts	24	22	16	41	13	201	NA ‡	53
No. HH	Variable	4,173	1,950	3,053	1,798	2,000	1,200	1,604

† Data drawn from previously existing surveys; ‡ Information not available